

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445439</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> - MAIN BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b>  <b>10/06/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>MT JULIET HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2650 NORTH MT JULIET ROAD</b> <b>MOUNT JULIET, TN 37122</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS  A Life Safety desk review was conducted on 03/04/2020 for all previous deficiencies cited on 10/06/2019. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>Poc LSC</i>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445439	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  03/04/2020
NAME OF PROVIDER OR SUPPLIER  MT JULIET HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122		
(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000			
	<p>Stories: 1 Construction Type: II unprotected Plans available Constructed: 1997 Sprinklered: Yes Census: 88</p> <p>A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 03/04/2020. During this Life Safety Survey, Mt Juliet Health Care was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012.</p> <p>The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:</p>				
K 920	Electrical Equipment - Power Cords and Extens	K 920			
SS=D	CFR(s): NFPA 101				
	<p>Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms</p>				

RECEIVED  
APR 03 2020  
BY: *sg*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Administrators* TITLE *Administrators* (X8) DATE *4/3/2020*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445439	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  03/04/2020
NAME OF PROVIDER OR SUPPLIER  MT JULIET HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2660 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 920	Continued From page 1 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the electrical equipment.  The findings included:  1. Observation on 03/04/2020 at 9:21 AM, revealed medical equipment plugged into power strip that was not UL 1363-A. NFPA 99, 10.2.4.2.1 (2012 Edition)  2. Observation on 03/04/2020 at 9:26 AM, revealed an extension cord used as permanent wiring in the service hall mechanical/electrical room. NFPA 99, 10.2.4.2.1 (2012 Edition)  3. Observation on 03/04/2020 at 9:53 AM, revealed an string of Christmas lights being used as an extension cord for a sound machine in room 311. NFPA 99, 10.2.4.2.1 (2012 Edition)  The maintenance director and regional maintenance were present when this deficiency was identified, and was later acknowledged by the administrator during the exit conference on	K 920	On 3/4/2020, the Maintenance Supervisor immediately removed the power strip, Christmas lights string, and extension cord discovered. On 3/6/20, the Maintenance Supervisor replaced the power strip found with a UL 1363-A power strip.  On 3/4/20, the Maintenance Supervisor performed an audit on all electrical outlets for non-medical rated power strips, extension cords, and Christmas light strings, with no adverse findings.  On 3/4/20, education was initiated by the Maintenance Supervisor with all staff regarding the use of medical-grade power strips identified as having UL 1363-A only, not using extension cords and not allowing Christmas lights to be used as a power source. Education will be completed by 4/24/20.  The Maintenance Supervisor and/or designee will conduct a random audit of five (5) rooms/areas weekly for four (4) consecutive weeks for incorrect power strips, Christmas lights used as a power source, and extension cords in use. The Administrator and/or designee will immediately address any adverse findings and report before the facility's Quality Assurance and Performance Improvement Committee for further review and recommendation.	4/24/2020	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445439	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  03/04/2020
NAME OF PROVIDER OR SUPPLIER  MT JULIET HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 920	Continued From page 2 03/04/2020.	K 920			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/04/2020
NAME OF PROVIDER OR SUPPLIER  MT JULIET HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments  A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 03/04/2020. During this Emergency Preparedness Survey, Mt Juliet Health Care was found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73.	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]* Administrator

4/3/2020

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.